MEDICARE ADVANTAGE:
What Everyone Needs to Know

What are Medicare Advantage Plans?

Medicare Advantage (MA) plans are private health insurance products that provide Medicare benefits to beneficiaries who choose to enroll in these plans. Currently, approximately 8.3 million (19%) of Medicare's 43 million beneficiaries are enrolled in MA plans; under current law, by 2017, CBO assumes that 25 percent will be enrolled in MA plans. The Centers for Medicare and Medicaid Services (CMS) spent $56 billion on Medicare Advantage in 2006.

There are eight different types of MA products, including local HMOs, preferred provider organizations (PPOs) and private fee-for-service (PFFS) plans. Availability of these plans varies by geographic area. Enrollment is focused in urban areas, but has been expanding to rural America with the advent of new MA products.

MA plans must offer all Medicare Part A (hospital/inpatient) and Part B (physician/outpatient) benefits, but they are allowed to change the cost-sharing for those benefits provided the total package remains equivalent in value to the regular A/B benefits. For example, MA plans may require higher hospital or durable medical equipment co-payments than traditional Medicare or impose a co-payment on home health services, which beneficiaries in traditional Medicare do not face. In exchange, beneficiaries may have lower co-payments for other A/B services.

There is evidence that the benefits are structured to attract healthier beneficiaries and avoid those who are more medically needy. MA plans may also offer additional benefits that are not covered by traditional Medicare, such as eyeglasses and yearly physical exams, but beneficiaries usually have to pay a supplemental premium for the extra benefits. There are no data available to confirm the extent to which beneficiaries actually need and receive the "extra" benefits offered by MA plans.

How Are MA Plans Paid?

Medicare Advantage plans are paid capitated rates to care for Medicare beneficiaries. When managed care plans first came to Medicare they were paid 95% of the cost of a Medicare beneficiary in traditional FFS Medicare because plans said they could do it better, cheaper. Today, plan payments vary dramatically in different parts of the country as Congress has modified the statute to encourage the growth of MA plans.

According to the non-partisan Medicare Payment Advisory Commission (MedPAC), MA plans are paid *on average* 112 percent of what it would cost to provide care in the traditional Medicare program. In other words, for every Medicare beneficiary who enrolls in a MA plan, the program pays 12% more than it would if that beneficiary remained in traditional Medicare. However, plans in some localities actually get paid more than 150 percent of Medicare fee-for-service payments. These overpayments have led to an explosion of MA plans; plan contracts have increased 151 percent since 2002, and each contract can cover hundreds of local plans.

MedPAC recommends equalizing payments between MA and traditional Medicare. The Congressional Budget Office (CBO) has scored the MedPAC recommendation as saving $65 billion over 5 years and $160 billion over 10 years. Even a reduction in MA payments to 100% of traditional Medicare would still allow MA plans to compete in the Medicare program. Those plans that are actually more efficient than traditional Medicare could still provide additional benefits to Medicare beneficiaries.

How Does MA Payment Lead to Higher Premiums for All Beneficiaries?

While only 19% of Medicare beneficiaries are enrolled in MA plans, all 100% of Medicare beneficiaries are paying higher premiums according to MedPAC. Because MA overpayments increase Part B spending, Medicare premiums for all beneficiaries go up, even those in traditional Medicare. In addition, MA overpayments deplete the

Medicare Trust Fund faster than would occur if payments were equalized with traditional Medicare.

Issues

The health insurance industry, led by the America's Health Insurance Plans (AHIP), has begun an aggressive lobbying campaign to oppose ANY payment reductions. Plans argue that any changes to the MA payment structure will destroy the program. AHIP and the Blue Cross Blue Shield Association have each recently released reports asserting that minorities and low-income beneficiaries would be adversely affected by reducing the MA overpayments. In reality, low-income and minority enrollment in Medicare Advantage is consistent with the overall proportion of minorities and low-income beneficiaries in Medicare as a whole (see attached Fact Sheet, and letter from Ken Thorpe to Ways and Means Health Subcommittee Chairman Stark regarding these claims).

The dramatic growth of PFFS MA plans is the biggest area of concern for policymakers. PFFS plans look very different from HMOs. These plans are not required to coordinate care and most do not have networks of providers. The PFFS plans are paid on average 119 percent of what it would cost to care for the same beneficiaries in traditional Medicare, though in some areas payments to PFFS plans are actually much higher. There is no evidence that extra payments to these plans result in extra benefits for beneficiaries.

In 2003, only 26,000 Medicare beneficiaries enrolled in PFFS plans; as of January 2007, there are more than 1.3 million enrollees, a growth of nearly 5,000 percent. According to both MedPAC and CBO, growth in these plans will increase the average overpayment to MA plans beyond the current average of 112 percent (new data will be available in June).

Tradeoffs

There are less costly and more efficient ways than MA plan overpayments to provide all Medicare beneficiaries with enhanced benefits. Improving the Medicare Savings Programs, which assists

lower-income Medicare beneficiaries with the cost of Medicare premiums and cost-sharing, and improvements to the Part D drug program low-income subsidy would help all beneficiaries, not just those enrolled in private plans.

Under pay-go, any increase in spending must be offset with equal program savings. In the hopes of making program improvements for all beneficiaries, no one area of Medicare should be considered off-limits to providing savings. In fact, there are a number of health care priorities that will require substantial offsetting savings this year.

- **State Children's Health Insurance Program (SCHIP) –** Insurance coverage for lower-income children is one of the most important Democratic health care priorities this year. Reauthorizing, improving and expanding the SCHIP program could cost $50 billion or more.

- **Medicare physician payment –** Payments for physician services under Medicare are scheduled to decrease by nearly 10 percent in 2008 unless Congress intercedes. Congress has always worked to protect doctors from these cuts, but eliminating the cut permanently could cost $330 billion over 10 years. Even a short-term solution is likely to cost a considerable amount.

- **Part D –** Most improvements to the Medicare drug program will cost money. Due to the President's promise to veto drug price negotiation, other areas of Medicare will be the likely target to pay for Part D improvements.

There are only a limited number of options to consider when searching for savings in the Medicare program. Taking MA payments off the table means hospitals, doctors and other fee-for-service Medicare providers may face significant cuts.